



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS ORTHOPEDIC HOSPITAL
3702 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098-3926

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

PACIFIC EMPLOYERS INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-09-B010-01

MFDR Date Received

AUGUST 3, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the carrier in this case. The carrier's position is incorrect and in violation of the Hospital Facility Guideline for outpatient services."

Amount in Dispute: \$10,519.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier or their agent did not submit a response or position summary to the request for medical fee dispute resolution. The carrier received notice of the dispute on November 6, 2009 as verified by the signed notice.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 8, 2008 – August 9, 2008	Outpatient Hospital Services	\$10,519.77	\$8,666.23

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 2, 2008 and October 30, 2008

- 45 – Charge exceeds fee schedule/maximum allowable or contract/legislated fee arrangement.
- (100) – Any network reduction is in accordance with the network referenced above.
- (113-001) – Network import re-pricing – contracted provider.
- 58 – Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
- (729-001) – This service is not reimbursable in a hospital outpatient setting.
- 59 – Processed based on multiple or concurrent procedure rules.
- (607) – Reimbursement for this procedure has been calculated according to the multiple procedure rule.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- (243) – This procedure has been included in another procedure performed on the same day.
- W1 – Workers Compensation State Fee Schedule adjustment.
- (595-001) – The reimbursement amount is based on the Medicare reimbursement plus the percentage increase specified by the state.
- (595-003) – Reimbursement is based on the Medicare reimbursement plus the state specified percentage increase and implantable care out.
- D22, (920-001) – Reimbursement was adjusted for the reasons to be provided in separate correspondence. Temporary code to be added for timeframe only until 01/01/2009. Another correction of a data entry error has resulted in a revision to the previously recommended allowance.
- In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes 45 – Charge exceeds fee schedule/maximum allowable or contract/legislated fee arrangement; (100) – Any network reduction is in accordance with the network referenced above; and (113-001) – Network import re-pricing contracted provider. The Division requested the respondent to provide a copy of the applicable contract and documentation to support notification to the requestor in accordance with 28 Texas Administrative Code §133.4, pursuant to §133.307(e)(1) which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request." The respondent did not submit copies of the requested contract(s) or otherwise respond to the MFDR request for additional information. These reason codes are not supported. Pursuant to Texas Labor Code §413.011(d-3), which states, in pertinent part, that "the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract:(1) is not provided in a timely manner to the division on the division's request," the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are

publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7050 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7050 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 82435 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$6.42. 125% of this amount is \$8.03. The recommended payment is \$8.03.
- Procedure code 84132 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$6.42. 125% of this amount is \$8.03. The recommended payment is \$8.03.
- Procedure code 84520 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$5.51. 125% of this amount is \$6.89. The recommended payment is \$6.89.
- Procedure code 82947 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$5.48. 125% of this amount is \$6.85. The recommended payment is \$6.85.
- Procedure code 84295 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$6.72. 125% of this amount is \$8.40. The recommended payment is \$8.40.
- Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or

payment system other than OPSS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPSS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$3.31. 125% of this amount is \$4.14. The recommended payment is \$4.14.

- Procedure code 29827 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 42, which, per OPSS Addendum A, has a payment rate of \$2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,746.76. This amount multiplied by the annual wage index for this facility of 0.9997 yields an adjusted labor-related amount of \$1,746.24. The non-labor related portion is 40% of the APC rate or \$1,164.51. The sum of the labor and non-labor related amounts is \$2,910.75. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$2,910.75. This amount multiplied by 200% yields a MAR of \$5,821.49.
- Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 42, which, per OPSS Addendum A, has a payment rate of \$2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,746.76. This amount multiplied by the annual wage index for this facility of 0.9997 yields an adjusted labor-related amount of \$1,746.24. The non-labor related portion is 40% of the APC rate or \$1,164.51. The sum of the labor and non-labor related amounts is \$2,910.75. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$1,455.37. This amount multiplied by 200% yields a MAR of \$2,910.75.
- Per Medicare policy, procedure code 29822 is included in, or mutually exclusive to, another code billed on the same date of service. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted documentation finds that the modifier is not supported. Separate payment is not recommended.
- Procedure code 29828 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 42, which, per OPSS Addendum A, has a payment rate of \$2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,746.76. This amount multiplied by the annual wage index for this facility of 0.9997 yields an adjusted labor-related amount of \$1,746.24. The non-labor related portion is 40% of the APC rate or \$1,164.51. The sum of the labor and non-labor related amounts is \$2,910.75. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$1,455.37. This amount multiplied by 200% yields a MAR of \$2,910.75.
- Procedure code 94640 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPSS with separate APC payment. This service is classified under APC 77, which, per OPSS Addendum A, has a payment rate of \$24.69. This amount multiplied by 60% yields an unadjusted labor-related amount of \$14.81. This amount multiplied by the annual wage index for this facility of 0.9997 yields an adjusted labor-related amount of \$14.81. The non-labor related portion is 40% of the APC rate or \$9.88. The sum of the labor and non-labor related amounts is \$24.69. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$24.69. This amount multiplied by 200% yields a MAR of \$49.37.
- Procedure code 94640 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPSS with separate APC payment. This service is classified under APC 77, which, per OPSS Addendum A, has a payment rate of \$24.69. This amount multiplied by 60% yields an unadjusted labor-related amount of \$14.81. This amount multiplied by the annual wage index for this facility of 0.9997 yields an adjusted labor-related amount of \$14.81. The non-labor related portion is 40% of the APC rate or \$9.88. The sum of the labor and non-labor related amounts is \$24.69. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$24.69. This amount multiplied by 200% yields a MAR of \$49.37.

- Procedure code 97110 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$27.53. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83 yields a MAR of \$38.19. The recommended payment is \$38.19.
 - Procedure code 97001 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is \$70.20. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83 yields a MAR of \$97.37. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of \$94.25. The recommended payment is \$94.25.
 - Procedure code J2405 has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. This service is classified under APC 768, which, per OPPS Addendum A, has a payment rate of \$0.26. This amount multiplied by 60% yields an unadjusted labor-related amount of \$0.16. This amount multiplied by the annual wage index for this facility of 0.9997 yields an adjusted labor-related amount of \$0.16. The non-labor related portion is 40% of the APC rate or \$0.10. The sum of the labor and non-labor related amounts is \$0.26. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$0.26. This amount multiplied by 200% yields a MAR of \$0.52.
 - Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J1100 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J0735 has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. This service is classified under APC 935, which, per OPPS Addendum A, has a payment rate of \$62.78. This amount multiplied by 60% yields an unadjusted labor-related amount of \$37.67. This amount multiplied by the annual wage index for this facility of 0.9997 yields an adjusted labor-related amount of \$37.66. The non-labor related portion is 40% of the APC rate or \$25.11. The sum of the labor and non-labor related amounts is \$62.77. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$62.77. This amount multiplied by 200% yields a MAR of \$125.54.
 - Procedure code C9113 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
4. The total recommended payment for the services in dispute is \$12,042.54. This amount less the amount previously paid by the insurance carrier of \$3,376.31 leaves an amount due to the requestor of \$8,666.23.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$8,666.23.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$8,666.23 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	<u>August 16, 2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.